ADULT ORTHODONTIC ACQUAINTANCE

Date:_______________

Name:____Date of Birth_______________Age__________
Address____________________________________City______________________Zip__________
Telephone (home) (__)_______________Telephone (business) (__)_________________________
Email Address____
Biological Gender: M/F___ Present Day Gender Identity: ________________________________
Social Security #_____________________________ ☐ single ☐ married ☐widowed ☐ divorced
Employed by_______________________________________Occupation_______________________

Spouse's name____
Employed by_______________________________Occupation______________________________
Address____________________________________City______________________Zip__________

Dentist___________________________City______________________Telephone (__)____________
Physician_________________________City______________________Telephone (__)____________

Dental Insurance Information

Subscriber name___________________Date of birth_________Social Security or ID# ____________
Address____________________________________City________________State__Zip__________
Employer name____
Address____________________________________City________________State__Zip__________
Insurance Company____
Address____________________________________City________________State__Zip__________
Telephone (___)__________________________Group #____

Secondary Dental Insurance Information

Subscriber name___________________Date of birth_________Social Security or ID# ____________
Address____________________________________City________________State__Zip__________
Employer name____
Address____________________________________City________________State__Zip__________
Insurance Company____
Address____________________________________City________________State__Zip__________
Telephone (___)__________________________Group #____

Medical History

General Health ☐good ☐ fair ☐ poor Presently under medical care for________________________
Medication currently being taken (drug and dose)____
Medication allergies____
Latex allergies____
Do you need to premedicate for dental appointments? ☐yes ☐ no

Please complete second page

Patient Name:____________________

Please check yes or no to the following and date:

	yes	no	year		yes	no	year
Adenoids (removed)	y	n	_______	Heart disorder/murmur	y	n	_______
Arthritis	y	n	_______	Hepatitis	y	n	_______
Blood/bleeding problems	y	n	_______	HIV	y	n	_______
Bone disorder	y	n	_______	Hospitalized	y	n	_______
Diabetes	y	n	_______	Lung disorder	y	n	_______
Ear/nose infections	y	n	_______	Rheumatic fever	y	n	_______
Emotional	y	n	_______	Scoliosis	y	n	_______
Endocrine	y	n	_______	Speech difficulty	y	n	_______
Epilepsy	y	n	_______	Tonsils (removed)	y	n	_______
Fainting spells	y	n	_______	Sexually transmitted			
Glaucoma	y	n	_______	infection	y	n	_______
Currently pregnant (females)							

Please give any additional information or details necessary____

____

____

Dental History

Date of last dental check-up____

Injury or trauma to the face or teeth____

- Bruxism (teeth grinding) ☐ yes ☐ no
- Clenching teeth ☐ yes ☐ no
- Difficulty sleeping ☐ yes ☐ no
- Mouth breathing ☐ yes ☐ no
- Snoring ☐ yes ☐ no

Speech (difficulty in pronunciation) ☐ yes ☐ no

TMJ (Jaw Joint) ☐ clicking/noise ☐ pain ☐ earaches/ringing ☐ locking ☐ muscle soreness ☐ frequent headaches

Describe major reason for seeking orthodontic treatment_________________________________

Other family members with similar dental conditions___________________________________

Other family members with orthodontic treatment______________________________________

Have you had any experience with or seen another orthodontist?__________________________

Any additional comments____

How and when did you first hear about our office?_____________________________________

Whom may we thank for referring you to our office?____________________________________

Patient Signature____Date_____________

Head and Neck Questionnaire

Name: ____ Age: ______ Date: __________

1. Do you have frequent headaches?
   Yes No

2. Frequency:
   _____ x/week
   _____ x/month

3. What time of day do you have headaches?
   ____

4. Color area where head hurts:

5. Do you have clicking, popping, or grating noise in your:
   Right jaw joint? Yes No
   Left jaw joint? Yes No

6. Is the pain worse:
   Mornings _____ At meals _____
   Evenings _____ No specific time _____

7. Does the pain sometimes feel like it is in your ear?
   Yes No

8. Has your mouth ever locked open so you were unable to close it?
   Yes No

   Explain: ____
   ____
   ____
   ____

9. Have you had problems with other joints?
   Yes No
   Explain: ____

10. Have you had orthodontic treatment?
    Yes No
    When ________________ Where ____